STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERWALK COMMUNITIES LLC	401 SE SIXTH STREET EVANSVILLE, IN47713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for a State Residential Licensure Survey. Survey dates: August 29, 30, 31, September 1, 2011 Facility number: 011274 Provider number: 011274 AIM number: N/A Survey team: Diane Hancock, RN TC Amy Wininger, RN Census bed type: Residential: 77 Total: 77 Census payor type: Other: 77 Total: 77 Sample: 7 Supplemental sample: 5 These state residential findings are cited in accordance with 410 IAC 16.2. Quality review completed 9/2/11 by Jennie Bartelt, RN.	R0000	All residents have the potential to be affected.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R0153	(j) The facility shall observe safety precautions when oxygen is stored or administered in the facility. Residents on oxygen shall be instructed in safety measures concerning storage and administration of oxygen. Based on observation, interview, and record review, the facility failed to ensure the safety of stored oxygen cylinders, in that 3 oxygen cylinders were observed untethered in 1 of 1 oxygen storage area. This had the potential to affect 77 residents currently residing in the facility. Finding includes: In an interview on 08/31/11 at 2:20 P.M., LPN #1 indicated that full oxygen tanks were stored in the employee breakroom. During the environmental tour, on 08/31/11 at 2:30 P.M., the oxygen storage area was observed to be located in the employee breakroom. Three oxygen cylinders were observed to be freestanding and unsecured in the corner of the employee breakroom. At that time, Maintenance Assistant #1 indicated the oxygen tanks had always been stored in the breakroom and the tanks did not need to be secured. The Policy and Procedure for Liquid Oxygen Use, provided by the DoN [Director of Nursing] on 08/31/11 at 3:30 P.M. indicated, "...House supply of	R0153	All resident have the potential to be affected. The oxygen that is in the facility is now tethered in compatible metal cylinder holders as per supplier's recommendation. The supplier's delivery personal, nursing staff and maintenance personal have been in-serviced on proper storage of oxygen cylinders. An audit will be done by the director of nursing or his designee. This will be done weekly times four, monthly times 4 and quarterly times four to assure that oxygen tanks remain secured. Results of the audit will be forwarded to QA. In addition a sign will be posted as a reminder. The sign will read "Oxygen must be in proper metal housing and secured at all times". Exhibit A In-serviceExhibit B Posted SignExhibit C Audit Form	10/01/2011

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	oxygen will be stored in a vented room." The MSDS [Material Safety Data Sheet] for oxygen from the oxygen vendor was provided by the DoN on 09/01/11 at 10:25 A.M. The MSDS indicated, "...Section 7. ...Storage...Cylinders should be stored ...firmly stored to prevent falling or being knocked over...."			
R0246	(6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on observation, interview, and record review, the facility failed to ensure that a QMA [Qualified Medication Aide] received authorization from a licensed nurse before administering medications to 2 of 2 sampled residents [Residents #36, #5], in the sample of 7, and 4 of 4 supplemental sample residents [Residents #11, #8, #1, #16], in the supplemental sample of 5. The residents were reviewed related to administration of as needed medications. QMA #1 administered prn [as needed] medications without obtaining	R0246	All residents have the potential to be affected. The nursing staff, Nurses and Qualified Medication Aides (QMA), has been in-serviced on the proper procedure of the QMA's administering PRN medications. The DON or his designee will audit 10 percent of the Medication Administration Records (MAR) for PRN medications administered by QMA. This will be done daily times 2 weeks, once weekly times four weeks, once monthly times four months and then once quarterly times four quarters. An outside nursing consultant will	10/01/2011

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	the authorization of a nurse. Findings include: 1. On 08/30/11 at 2:00 P.M., Resident #36 was observed to approach QMA #1 at the nurses' station and request cough syrup. QMA #1 was observed to administer the cough syrup without receiving authorization of a nurse. The MAR [Medication Administration Record] of Resident #36 was reviewed on 08/31/11 at 10:00 A.M. The MAR indicated Resident #36 had received Guaifenesin DM 5 cc prn [as needed] from QMA #1. The Nurse's medication note lacked any documentation that the administration of Guaifenesin was authorized by a nurse. 2. The clinical record of Resident #5 was reviewed on 08/30/11 at 11:45 A.M. The July 2011 Physician's Order recap, signed 7/15/11, indicated Resident #5 was to receive Lortab 5 mg [milligram] [a narcotic pain medication] every four hours as needed. The August 2011 MAR [Medication Administration Record] of Resident #5 was reviewed on 08/31/11 at 10:00 A.M. The MAR indicated Resident #5 was administered Lortab five times prn [as		review these audits as well. The results of the audits will be forwarded to QA. Exhibit D In-service on PRN medication AdministrationExhibit E Audit Form for PRN Medications	

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	needed] by QMA #1 [08/2/11, 08/4/11, 08/9/11, 08/11/11, and 08/16/11. The Nurse's medication notes lacked any documentation that the administration of Lortab had been authorized by a nurse. 3. The August 2011 MAR of Resident #11 was reviewed on 08/31/11 at 10:00 A.M. The MAR indicated the Resident #11 had received Lortab 7.5 mg [milligram] prn eight times from QMA #1 [twice on 08/04/11, 08/05/11, 08/11/11 and once on 08/08/11 and 08/09/11]. The MAR further indicated Resident #11 had received Ativan 1 mg [anti-anxiety] prn three times from QMA #1 [08/04/11, 08/05/11, 08/11/11]. The Nurse's medication notes lacked any documentation that the administration of Ativan had been authorized by a nurse. 4. The August 2011 MAR of Resident #8 was reviewed on 08/31/11 at 10:00 A.M. The MAR indicated the Resident #8 received Benadryl 25 mg. [for allergic reactions] once [08/15/11] and Oxycodone [narcotic pain medication] 5/325 mg twice [08/04/11 and 08/15/11] from QMA #1. The Nurse's medication notes lacked any documentation the administration of Benadryl and Oxycodone had been authorized by a nurse.			

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	5. The August 2011 MAR of Resident #1 was reviewed on 08/31/11 at 10:00 A.M. The MAR indicated that Resident #1 received Benadryl 25 mg prn six times [08/08/11, 08/09/11, 08/11/11, 08/15/11, 08/16/11, 08/17/11] from QMA #1. The MAR further indicated Resident #1 received Imodium 4 mg [anti-diarrhea medication] once [08/15/11] from QMA #1. The Nurses medication notes lacked any documentation that the administration of Benadryl and Imodium had been authorized by a nurse. 6. The August 2011 MAR's of Resident #16 were reviewed on 08/31/11 at 10:00 A.M. The MAR indicated the Resident #16 received Ativan 1 mg prn once [08/28/11] from QMA #1. The Nurses medication notes lacked any documentation that the administration of Ativan had been authorized by a nurse. 7. The policy and procedure for medication administration was provided by the DoN on 08/31/11 at 3:00 P.M., "...5. QMA's will inform the licensed nurse when a resident is in need of a PRN medication. The licensed nurse will sign off on the PRN medication with the QMA...." 8. In an interview with the DoN, on 08/31/11 at 12:45 P.M., he indicated,			

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	"The QMA should tell the nurse, the nurses should assess and initial with the QMA."			
R0306	(g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug.			
	Based on record review and interview, the facility failed to ensure the disposition of medications for 2 of 2 sampled residents who were discharged from the facility, in the sample of 7, was documented in the residents' records. (Residents #78, #79) Findings include: 1. Resident #78's clinical record was reviewed on 8/31/11 at 10:30 a.m. The evaluation of the resident, dated 12/14/10,	R0306	All residents have the potential to be affected. The nursing staff, Nurses and QMA's have been in-serviced on the proper procedure of documenting medication disposition of discharged residents. Two nursing personal will sign off on the medication disposition form to assure procedures are followed correctly. Upon discharge each resident file will be audited by the DON or his designee to assure proper	10/01/2011

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	indicated the facility administered the resident's medications. The resident had been discharged from the facility on 8/9/11, to another facility. The record failed to include documentation of the disposition of her medications. 2. Resident #79's clinical record was reviewed on 9/1/11 at 9:30 a.m. The resident had a physician's order, dated 7/18/11, indicating, "May discharge to [name of apartment complex] with meds [medications]." There were discharge instructions, including a medication list, but there was no accounting for the prescription numbers, the number of medications, and the disposition of the medications, i.e. what exactly was sent with the resident. 3. Interview with the Director of Nurses, on 9/1/11 at 10:55 a.m., indicated the records did not contain disposition of medications upon discharge.		disposition of medications and proper documentation is in resident file. An outside nursing consultant will review these audits as well. The results of the audits will be forwarded to QA. Exhibit F In-service for proper medication disposition and documentation Exhibit G Audit form for discharged residents	